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ABSTRACT

This paper explores ways in which school counselors can help young people with death-related concerns. It is often assumed that school counselors have the necessary skills for working with students who experience grief, but most graduate counseling curricula do not require courses in death education; thus, many counselors feel uncomfortable in helping clients deal with death-related concerns. Some of the topics covered in this paper include the changing face of school counseling and the need for counselors to be exposed to death education course work. Some topics for death education are described, along with a chapter-by-chapter analysis of the text "Death and Dying Life and Living," which looks at four different cultural views of death. This text describes the four phases a person must work through and offers advice on how to help children and adolescents cope with issues surrounding dying and death. The paper then describes myths common to grief and mourning, such as the belief that grief and mourning are the same experience. Myths involving children's reactions to death are also examined. Suggestions for grief counseling are offered and ways in which to apply grief counseling principles are provided. Contains 52 references. (RJM)

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DEATH EDUCATION AND GRIEF COUNSELING

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CHAPTER I: INTRODUCTION

PURPOSE OF STUDY:

The purpose of this descriptive study was to examine the school counselor's role in assisting young clients through the grief process. Although the research emphasized that an abundance of death related literature existed, it often assumed that the school counselors possessed the necessary skills for working with the grief and death concerns; however, many counselors felt uncomfortable working with students or clients who had death related concerns. Most graduate counseling curricula do not include a required course in death education.

DEFINITIONS: The following definitions were important to this study:

Bereaved person--any person who feels that the death of a person has deprived, robbed, plundered, or stripped him/her of something of value.

Bereavement--the term that identifies the objective situation of individuals who have experienced a loss.

Grief--the response to loss. Grief includes the thoughts and feelings a person experiences when someone he/she love dies. It is the internal meaning given to the experience of bereavement.

Mourning--the external expression of grief.

Reconciliation--the process that occurs as the bereaved person works to integrate the new reality of moving forward in life without the physical presence of the person who died.

BACKGROUND:

My "Master's Project" actually began to take life before I entered Fort Hays State University to work on a graduate degree in counseling. Being an older teacher when I started my teaching career, students would approach me with their problems. I always tried to answer them as honestly and openly; however, as a teacher who just listened as the students worked through their problems, I wondered if the preparation I received in my undergraduate education program at the University of Kansas had really provided me with the skills I needed to assist my students.

As more and more students were approaching me with their problems, students, co-workers, and administrators encouraged me to think about entering a counseling program. Several major tragedies showed me that I personally lacked preparation in a major area--death and grief. I applied for admittance to the Graduate School Counseling Program at Fort Hays State University, Hays, Kansas, in the summer of 1991, not particularly to be a counselor, but to be a more skillful educator.

The structure of the core curricula in the counseling program at Fort Hays State University served as a strong nucleus for me to learn the concepts necessary to be an effective counselor. As I advanced through the counseling, the emphasis was on counseling as a profession. Much of the course work consisted of: the historical background; the ethical issues; the techniques and ideologies of major theorists; the multicultural

issues in counseling; the modes for appraising individuals, including, methods, instruments, and interpretations; the dynamics involved in managing and maintaining a productive school counseling program; and, most importantly, the essential attending and communication skills necessary to counsel a person in an individual or group setting.

All the while I was taking my graduate courses, I was searching for a course that would help me in death related areas. In the spring of 1994, I found it. It was an undergraduate class which meant that I would not get any credit towards my graduate degree, but that did not matter. The Sociology Department at FHSU was offering an audiocassette course "Sociology of Death and Dying" taught by Dr. Gerry Cox. That same spring, I taught six hours of high school English courses and one College English Composition II class every day at Sylvan Unified High School, taught a night College English Composition I class, took ACES 834: Appraisal of the Individual one night a week at FHSU, and Sociology 455.

Since my first day in graduate school, everyone seemed to keep telling me I needed to select a topic for my Master's Project. I had just completed an elementary readings course with Dr. Stansbury, and I had started working on another independent study when I knew I wanted to do my project on death and grief counseling. In the summer of 1994, I had angioplasty. No problem, then in the fall, I had a major heart problem requiring by-pass surgery. I went through the process of listening to the

doctors as they explained the procedures they would use. The nurses gave me information concerning a "living will" and "organ donations." Suddenly, I began to wonder whether I would ever finish and receive my degree. When they wheeled me into surgery, there was cart after cart filled with surgical instruments. When asked if I had filled out a "organ donor" release, I told them "yes," but for them to try and save me before using me for "spare parts."

Although I had completed my written competency exams, I decided to wait to start on my project, although I kept reading. I was a teacher who loved teaching, but I was beginning to do more and more counseling. In the spring of 1995, a friend suffered a debilitating stroke. Since he had neither a "living will" nor left "oral instructions" at any time, his wife had to make the decision as to whether he remained on the machines. There was much discussion about the pros and cons of the decision, but she decided to leave him on machines. He lives in a vegetative state. I decided I did not ever want that to happen to me, so, I wrote a "living will" giving clear instructions as to what "heroic" efforts I want, and when to stop. My entire family knows about what I want.

In the January of 1996, I had several mini-strokes. I knew something was wrong, but it took a month for doctors to find that I required surgery on both blocked carotid arteries. I knew something was wrong, but I did not know what. Dr. Stansbury teased me that I was trying to obtain first hand information on

death. In a way, he was right. While I was putting off my project, I was gathering information--although not quite the way I would have chosen. I learned about writing a "living will" and giving "organ donor" permission under duress verses writing a "living will" and giving "organ donor" permission without any immediate pressure. It was easier when I could spend time and really think about what I personally wanted. I also gained the realization that I am mortal.

In the fall of 1996, I attended a counselor's meeting at Fort Hays State University. Several former classmates, now school counselors, encouraged me to go ahead and complete my project on death and grief counseling. They felt the information was vital. Many had experienced student deaths which required them to handle grief concerns, and they realized that they were unsure of what to do. One told about facing a student suicide within the first month of her starting her school counseling career. They wanted me to give them the skills necessary to help the bereaved student/client--they already possessed them.

In his Western Attitudes Toward Death (1974), Philippe Aries traced the attitudes of people toward death in Western civilization from the Middle Ages to the 20th Century. Until the early 20th Century, death and life appeared intertwined, and people accepted death as a natural part of life. The 20th Century, according to Aries, became the age of "forbidden death." Stillion (1989) attributed four trends that lead to social

estrangement from the topics of death and dying.

The first trend was the lengthening of life expectancy. Across the time period from 1920-1975, life expectancy in the United States increased 18.5 years. Many people, for the first time in history, could expect to live to old age without experiencing the death of a loved one.

The second trend was the migration from the farm to the city and suburbs. In 1920, one out of three families lived on farms and identified themselves as living primarily from the land; whereas, in 1970, less than five percent of our population identified themselves as farmers. The natural rhythms of birth, life, and death, so evident in farm life, were less visible to city dwellers.

The third factor was the growing trend toward technological innovation and specialization in occupational areas. A myriad of medical specialists replaced the family doctor. Oncologists, radiologists, surgeons, and nurses of all specialities took over the care of seriously ill patients. The dying process moved from the home to the hospital, further distancing the families from both the processes of dying and the event of death. Funeral directors handled all details of preparing and burying the deceased.

The fourth trend affecting the attitudes toward death and dying was the increasing secularization of the United States' society. Even though many religious denominations grew in numbers during the first third of the 20th century, the general

trend since the 1970s, was a shift away from the traditional attitudes and values associated with many rites of passage. Marriage ceremonies became "happenings" rather than solemn events. Memorial services celebrating the life of the deceased replaced traditional funeral and grave side services. Some of these ceremonies glossed over or totally neglected the reality of death. The nature of such ceremonies, at the extreme, resulted in reinforcing the principle that a person should ignore death, and that death was not a topic for public discussion.

Death has become as invisible as humans could possibly make it. Specialists, more oriented and committed to prolonging life at all cost, took over the care of terminally ill people. When death occurred, it most commonly happened in sterile hospital surroundings, with the patient hooked by useless technological lifelines to whirring machinery. When the medical community could no longer deny the reality of death, they called the funeral director to pick up the body and prepare it for viewing. No longer did family members care for the dying or perform the last services of preparing the body and digging the grave. All of these services were in the hands of specialists, who, in an increasingly death-denying society, worked hard to move death to the periphery of human experience.

As the physical distancing of individuals from the reality of death became pervasive, psychological distancing from the subject of death also occurred. We became a nation of people who did not discuss death easily or often. As Gorer writes in his

"Pornography of Death" in Death, Grief, and Mourning (1967), we invented euphemisms to soften death's reality. We communicated our "dis-ease" about the subject to our children and abandoned them to the death educators of the television, movies, and their own life experiences. In 1993, years after Gorer's writing, T.V. violence and death came to the forefront in Congress as reported in the Congressional Quarterly Report. The average American child watches 8,000 murders and 100,000 acts of violence before finishing elementary school.

For too many young people, schools offer no safe haven. How sad that in today's world, more teens die of violence--especially gun violence--than any illness. According to the National Center for Health Statistics, homicide by firearms moved into second place as a leading cause of death (after motor vehicle crashes) for the 15-19 year old Caucasians. For African Americans in that age bracket, homicide became the leading cause of death (Wolfelt, 1996).

We became a nation whose main modes of dealing with death and death related issues were avoidance and denial. Unfortunately, we can no longer ignore death because our children are dying.

SIGNIFICANCE OF THE REPORT:

The results indicated that although a person might take a death education course, it does not always follow that the person will be any better at dealing with death and grief issues. However, by focusing on the individuality of grief and the helping skills a counselor already possesses, a school counselor can assist young people as they try to understand the changes in their lives.

CHAPTER II: REVIEW OF RELATED LITERATURE

SOURCES:

The key descriptors utilized in the bibliographic search for information for this study were as follows: *death; death education; thanatology; grief;* and *bereavement.* The Thesaurus of ERIC Descriptors was the reference that determined the terms or descriptors for use in the search of the Educational Resources Information Center (ERIC) documents.

Sources extensively employed for this search were Resources in Education (RIE) and Current Index to Journals in Education, the print forms of ERIC, in addition to the CD-ROM form of ERIC. Additional preliminary resources consulted were TOPCAT, Education Index and Library Literature.

The researcher also used the bibliography in the text Death and Dying Life and Living (Corr, Nabe, & Corr, 1994); scanned the table of contents of magazines on thanatology, such as: Omega and Death Studies; and, selected reference sections in many of the articles which served as excellent guidance on numerous other works on the same topics. These works pertained specifically to articles that contained information about death education, death studies, and grief counseling.

REVIEW:

The research in this study dealt with the issue of death education for school counselors to strengthen their ability to work with young people in areas of death related concerns. The topical arrangement of related material was to enhance the coverage of necessary material in each section.

The Changing Face of School Counseling

Major transformations in the dynamics of the "family" structure has directly influenced the social institution of education. Three major factors appear responsible for the evolution. The first factor is the estrangement of the extended family because of mobilization since World War II; the second factor is the reconstruction of the "traditional" nuclear family because of divorce and "blending," plus, the growth of single parent families due to single-parent adoptions, divorce, separation, desertion, and unwed parenthood; and, the third factor is the movement of the religious family away from spiritual to more secular beliefs.

With the school being the primary environment for young people during the major portion of the year, society looks frequently to its schools for social, moral, and educational guidance. As children and adolescents bring emotional "baggage" to school, the classroom teachers and counselors must prepare themselves to deal with the traumas that could block the way that students develop and learn.

Since the classroom teacher is the one person with whom a

young person has daily contact, the teacher is usually the first person the student approaches with a problem. When the topic concerns a discussion of death, too often, the teacher tries to divert the young person to another subject; however, when the subject of death is not in the abstract, but in reality, that moment is not the time for a teacher to realize that his/her undergraduate curriculum did not cover topics related to death and dying. The thought of actually discussing such a "morbid" subject as death leaves some teachers flustered. The student is then sent to the person who is "everything to everyone"--the school counselor.

Most school counselors are former classroom teachers. They are often as uncomfortable, maybe even as terrified with the topic of death as the classroom teacher who referred the student (Nelson, 1977). Although people assume that counselors possess the skills and knowledge to help in the realm of grief and death, most school counselors are "poorly prepared" to work in this area (Rosenthal, 1981; Basque & Krieger, 1974). According to Rodman (1997), most school counselors use the "problematic" style of counseling. Here is the "problem" -- "here is the "answer." Counselors use their own life experiences when working with young people, but an increasing number of counselors have not suffered the loss of someone close to them. Usually, a death has occurred before the student or teacher approaches the school counselor.

Ideally, parents should handle the topic of death lovingly at home; however, parents find the topic of death even more

difficult to discuss than sex (Nelson, 1977). While administrators encourage counselors to help students with death related problems, they forbid discussion of death in the classroom (Rosenthal, 1981). Just as many school programs ignore sex, they also ignore death (Nelson, 1977). Elisabeth Kubler-Ross writes about how we live in a "death denying society" in her book, On Death and Dying (1969), and she refers to young people as the "forgotten ones."

Although society does not think death and grief are a problem young people face at an early age, studies show that is an erroneous assumption. A study by Ewalt and Perkins (1979) indicated that as many as 90% of junior and senior high students experienced a loss associated with death. They go on to say that 40% experienced the death of a close friend, while 20% claimed they had witnessed a death. Statistics understate the frequency in which today's teenagers have had to confront the death of a peer (Schachter, 1991). Some students will face the death of a parent before they leave the educational system. Students will also experience the deaths of aunts, uncles, grandparents, and out-of-town friends of the family. It will be an extremely rare year that leaves students, administrators, teachers, and counselors untouched by the experience of death (Getson & Benshoff 1977).

Society in general is neither comfortable with adolescents nor comfortable with the topic of death and grieving (Hodges, 1988), but the fact remains that no matter how much society

denies death, it is a violent reality for our youth.

The leading cause of death for the 15-19 year old Caucasians is motor vehicle accidents. This figure has held constant over the decades; however, homicide by firearm is now the second leading cause of death, displacing suicide. Homicide by firearm is the leading cause of death among African Americans (Wolfelt, 1996). Since the leading causes of adolescent deaths are violent, it makes peer deaths more difficult for adolescents to deal with (Schachter, 1991). Again, in response to society's outcry that the educational system must react to the needs of these grieving young people, schools are creating "Crisis Response Teams."

Death Education Course

Many viable reasons exist for a school counselor to take a death education course, but the major consideration is the counselor himself/herself. Reared and instructed at varying levels in a "death denying" society, it is difficult for many people to speak or listen to others as they speak honestly concerning their feelings when it involves death (Corr, Nabe & Corr, 1994). An adult may feel uncomfortable and incompetent when dealing with death (Weeks, 1989), but an adult needs to receive a child's death related questions without anxiety or nervousness (Pope, 1979). Pope emphasizes that children can sense an adult's uneasiness and can tell when an adult is trying to "brush" them or their concerns aside.

Before an individual can communicate effectively with

others, he/she needs to define how he/she views life (Corr, 1984; Bascue & Krieger, 1974; Wolfelt, 1992 & 1996), and death is a part of life. Some people view the idea of even discussing death and dying as repulsive. Maybe a person should be able to work through death and death-related issues concerning self, but without a required structured method, most people would not scrutinize differing concepts on these topics. People put off even thinking about life and death, but through a close examination of a person's own beliefs, he/she can find his/her own philosophy of life and death. Acknowledging the reality of death does not lead us to prefer death to life. It allows to factor death into living. A person can learn to enjoy life more through an awareness of its end.

Basque and Krieger (1971) relate that counselors hinder their clients in moving through the dying, death, and grieving processes because the counselors do not know about themselves and their own responses. A counselor needs to evaluate his/her own views concerning life and death, and how these beliefs function as a part of his/her total personality. It is extremely important for the counselor to realize that a death education course is for self-exploration. Unless he/she understands his/her own ideas, he/she might have serious problems facilitating the needs of others without being judgmental. "Healthy children will not fear life if their elders have integrity enough not to fear death" (Erikson, 1963, p. 269).

Topics for Death Education

Charles Corr (1984), a leading authority in the establishment of death education courses, thinks that a death education course should be a "broad-based, credit-bearing, full-term course that is part of the regular academic curriculum of a college or university" (p. 12). Corr suggests putting the words "Death" and "Children" together. His reasoning is as follows:

> For many adults the terms "children" and "death" seem incompatible. Deep in our gut, even though we know intellectually that these associations are less than fully accurate, children suggest beings that are good, innocent, and pure, while death implies an event that is evil, malignant, and repugnant (13).

What age is a child? "Children" can suggest infants, adolescents, young people, and even the "adult child" buried at the age of fifty-five by an eighty-year-old parent. Corr goes on to say that the "legitimate scope of these words stretches the mind to entertain multiple pairings, not all of which are or need to be offensive or morbid" (13).

Death and Dying Life and Living (Corr, Nabe, & Corr, 1994) is the resourse text currently in use for Sociology 455: Sociology of Death and Dying, an independent study audiotape Continuing Education course offered by Fort Hays State University. The text contains six major sections, with each section broken down into three to four chapters. The format is excellent for a death education course.

"Part I: Death" deals with the historical and cultural background since the Middle Ages to the present. These chapters show the changing encounters with death and the changing attitudes toward death. The contemporary American death system and cultural differences complete the first part of the course. The authors breakdown the first part into four chapters.

Chapter 1: "Changing Encounters with Death" relates the changes which are happening in society. This chapter explains changes in mortality rates, in the causes of death, in where people choose to die, and in historical altercations. During the twentieth century, life expectancy in the United States has increased from less than fifty years of age to approximately seventy-five years of age. Three factors helped create the 50 percent increase in life expectancy in a period of 100 years. The first factor was the major historical and social phenomenon of industrialization; the second factor reducing mortality was public health measures; and the final factor was modern medicine. With the population in the United States aging, degenerative rather than communicable diseases became the leading cause of death, and the majority of people began dying in institutions rather than at home.

Chapter 2: "Changing Attitudes Toward Death" deals with the dominant pattern changes in the United States. According to the authors: "Patterns of death-related attitudes have changed before; they can, and will, change again" (p. 48). This chapter goes into the beliefs, feelings, behaviors and underlying values

that make up the dominant pattern of death related attitudes in the United States today. Contemporary society often "banishes death." Many people are uncomfortable around a dying person. It reminds them that they are mortal. They do not worry about how the dying person feels, but how they feel. The dying are "banished" to institutions so people feel more "comfortable." Death occurs and no one is there at the moment of death; the person is alone; the dying has no control or say in his/her own death. Aries claimed: "death belongs now to bureaucrats."

Chapter 3: "The Contemporary American Death System" identifies several of the most important features of the contemporary American death system. The emphasis is attitude toward death. The society shows its evident discomfort in talking about death by using euphemistic language when dealing with dying, death, and death related topics. Embalming became vogue, not to preserve the body, but to hide all trace of death. All these changes make death more socially acceptable.

Chapter 4: "Cultural Differences and Death" shows how different cultures have distinct ways of dealing with death. The authors warn that it is vital for a person to be careful and not to stereotype when assessing cultures different from his/her own culture. Ethnocentric thinking can cause a great amount of damage, and has no place in the counseling sphere.

Banks and Banks (1993) in Multicultural Education explains how an individual belongs to several different groups simultaneously, and each group interrelates. The major six

groups to which a person belongs are gender, nationality, race/ethnicity, religion, social class, and exceptionality/non-exceptionality. These multicultural factors enter the total individual cultural arena. Banks and Banks caution that: "Membership in a particular group does not determine behavior but makes certain types of behavior more probable (p. 14). Lee and Richardson (1991) give good insight into the workings of the different cultures and their functions in Multicultural Issues In Counseling: New Approaches to Diversity. It is an excellent resource book for school counselors.

Corr, Nabe and Corr (1994) explain that when looking at cultural differences on death within a group, it is necessary to look at three specific areas: one, a group's encounter with death; two, a group's attitudes toward death; and three, a group's death related practices or how each group copes with dying, death, and bereavement.

Although there are many different groups in the United States' pluralistic society, Life and Living Death and Dying looks at only four different cultures--African American, Hispanic American, Asian American, and Native American to illustrate the of cultural differences. The largest minority group in the United States is the African American community. African American infant morality rates are the highest of any group. Deaths from violence are high among males in the population, but suicide rates are lower than Caucasian Americans. Also, the rate of AIDS is higher in this cultural group as well.

The African Americans tend to mistrust the medical community, and generally take care of their dying at home rather than place a person into some type of nursing home. The African American population believes in unrestrained grief among all mourners--male as well as female. The funeral practices include singing by choirs, soloists, and congregation. Eulogies and testimonials of friends are an important part of the service.

The second largest minority group in the Continental United States is the Hispanic Americans. Researchers have found some problems researching encounters with death among Hispanic American groups. Few records separate out people of Hispanic origin from other groups. Often statistics list them as Caucasian. Some researchers use Spanish sounding surnames, but this method can be misleading. As far as researchers can verify, the populations of Hispanic origin take on much of the culture where they reside. Death rates are about the same for the Hispanic American as the Caucasian American.

Family and religion appear to shape the attitudes of Hispanic Americans. Using the Mexican American population as a sampling basis, researchers have made some generalities for the entire group of Hispanic Americans. Most Mexican Americans are Catholic; therefore, suicide among these groups are low, or possibly reported as death by other means. Funerals are very important to this group. Generally, there is a large wake, and funerals tend to be big, well-attended affairs. Family and friends want to spend as much time as possible with the extended

community. While encouraging women to grieve openly, the group considers it inappropriate for males to express unrestricted emotions.

The third group is the Asian American community. The Asian Americans are usually very private, and consider it unacceptable to complain, so medical personnel may find it hard to treat the patient. Asian Americans are unwilling to tell a dying person that he/she is dying. Funerals are well-attended, and this group tends to take many pictures to keep a record of the event. Asian Americans are more acceptable of suicide, and as a group, they prefer cremation.

The fourth group is the Native Americans. Because each Native American group has different beliefs, and patterns of behavior and rituals, it is difficult to provide many clear differences. The one area where all groups seem to agree is in dealing with the dying. Native Americans do not want a dying person within the home. They believe that if a person dies within the home, the spirit will linger after the person dies. They are very hospital or nursing home oriented. Native Americans are reluctant to discuss death and death practices.

Part II: of Death and Dying Life and Living is titled "Dying." This section looks at death as a process, in fact, dying is a life long process. With the lengthening of life expectancy, society is growing older. It is necessary to facilitate the dying as he/she goes about doing the daily tasks required of him/her. The authors state: "Dying persons are living human

beings" (104). These three chapters give exceptional insight on how to work with a person who is dying.

Chapter 5: "Coping with Dying" deals with the person who is actually dying. It goes into the fears, concerns, and anxieties of the dying person. The dying person has issues that he/she must face. The dying person must cope with the illness, cope with details that he/she feels a need to address before dying, and cope with the living. In the past, the American death system advised people not to speak candidly to a dying person about he/her diagnoses and/or prognoses because they felt it would "undercut hope and the will to live." Professionals or lay people who work with the dying need to keep clear channels of communication open. They need to learn how to identify and respond effectively to the particular physical, psychological, social, and spiritual tasks that are a part of a specific individual's coping with dying. Sometimes, while doing these tasks, the helper needs to keep company with the dying and others who are coping with dying. This time may be stressful for the person who is assisting, but at times, "one has to be comfortable with one's own discomfort."

Chapter 6: "Helping Those Who Are Coping with Death" gets into the dimension of caring for the dying person. There are four major aspects of dying which caregivers need to address--the physical care, the psychological care, the social care, and the spiritual care. The chapter gets into how to assist the dying in coping with these different aspects. The main thing is to listen

and attend to what the dying person is saying. A facilitator needs to be alert, sensitive, and caring. The dying person needs to make his/her own decisions as to how to complete the tasks before him/her. It empowers the dying person to control his/her life as much as possible.

Chapter 7: "Hospice Principles and Caring for the Dying" goes into the workings of hospitals, long-term care facilities, and hospice programs. It gives a brief history of how the family and friends surrounding the dying person evolved to the person dying alone in a hospital or long-term care facility--"the denial of death." Hospice is a philosophy, not a facility, and offers "holistic" care to the dying person by reaffirming life not death. "The hospice approach seeks relevant ways to combine professional skills and human presence through interdisciplinary teamwork" (p. 149). As the population ages and medical costs raise, people are looking for alternative ways to care for the dying. The hospice program in the United States has grown over the last twenty years.

"Part III: Bereavement" contains an in-depth look into coping with loss and grief. It goes into ways to help people who are coping with the loss of a significant person. This section also goes into funeral practices and rituals. Chapter 8: "Coping with Loss and Grief" initiates an examination of the central elements involved in human experiences of loss, bereavement, grief, and mourning. Grief is the response to loss. Mourning is the process of coping with the loss and grief. Many writers feel

that mourning has phases. First, shock then numbness, next yearning and searching, followed by disorganization which leads to organization. It sounds simple, but there are tasks the grieving person must pass through to come to the organization. How quickly or slowly a person works through the grief process depends on the closeness or perceived closeness the person felt to the deceased. Wolfelt (1996) takes exception with this schema. The idea of disorganization that leads to organization is the "traditional medical model of bereavement care that teaches that the helping goal is to return the bereaved person to a homeostatic state of being" (p. 5-6).

He also states that experience "has taught me that we as human beings are also forever changed by the death of someone we love" (p. 5).

Corr, Nabe, and Corr give four phases they think a person needs to work through. First, a person needs to accept the reality of the loss; second, a person needs to work through the pain of the grief; third, a person needs to adjust to an environment in which the deceased is missing; and fourth, the person must emotionally relocate the deceased and move on with life. Most people move through these stages or tasks without realizing it is happening. However, sometimes a person might have problems dealing with a death and require professional help.

Chapter 9: "Helping Those Who Are Coping with Loss and Grief" reviews some ways in which individuals and society can act to help those who are coping with loss and grief. The authors

give examples of unhelpful messages and examples of helpful messages and actions. Generally, just being there helping a bereaved person is beneficial. Again, complicated grief requires professional assistance. Chapter 10: "Funeral Practices and Other Memorial Rituals" reviews different forms or burial and some ways of disposing of a body.

"Part IV: Life Cycle Perspectives" is very essential to any school counselor working with young people. These four chapters cover children, adolescents, adults, and the elderly. At each stage of life, a person has a different perspective of death and dying. Chapter 11 is simply entitled: "Children." Children--the very word makes a person want to protect the "little people" from all that is sad and traumatic. This attitude lead "many in American society to adopt a policy that assumes that children are unaware of and must be sheltered from all death-related events" (p. 241).

Children experience death--children die and children have loved ones who die--that is the nature of life; however, "American society and many of its members appear to undervalue their prevalence and importance for children" (p. 243). A child will see someone die on a television show, then, on another show, the person is alive. Since a child takes much of what he/she hears and sees literally, he/she is receiving a mixed message. Without some type explanation about "reality" and "make-believe," the child will seek answers he/she thinks is "plausible."

Death and Dying Life and Living delineates ways to assist a

child when he/she is coping with death--whether his/hers or the death of another. Children's questions may seem egocentric, but children and many adults have similar thoughts. Some questions children often ask when referring to the death of another are: "Did I cause it?" "Is it going to happen to me?" "Who is going to take care of me?"

Communication is vital when dealing with death related issues with children. There should be no "surprises." If the child is going to visit a dying person, the adult should tell the child exactly what to expect. Visiting a dying person could ease the child's sense of death. Children have very good minds; in fact, there are times when adults could learn much by listening to what the children are saying.

The socialization process begins at birth. A child learns by watching the people who are around him/her. Children learn by example. If adults speak about a person's dying or death only in hushed tones when they think a child is not listening, the whole event becomes some type of mystery or horror for the child.

Effective communication with children avoids euphemisms and inconsistent or incomplete answers because they can lead to serious misunderstandings. Harris (1995) states in The Loss That Lasts Forever that children have a limited vocabulary and they do not have a language of death. According to Harris, the death of a parent or caregiver is a catastrophic event for a child. They are hurting, but they do not have the language skills to express what they are feeling. Adults must learn to work with the

children.

Counselors who work with bereaved children think they should always know what to say and do. Wolfelt (1996) claims that many want a "cookbook, prescriptive approach to treating the child." He goes on to say:

> I have found that the need to fill silences and treat bereaved children as patients results from contamination by a medical model of mental health care-giving. This model teaches us to study a body of knowledge, assess patients and treat them with hopes of resolving issues and conflicts. In my experience, there is one major problem with this model as it applies to caring for bereaved children--it doesn't work! I have come to realize that the true expert in the counseling relationship is the bereaved child (p. x).

Every person goes through the "grief" process at his/her own pace and in his/her own unique way. The most important thing any person can do for someone who is dying or grieving is to "listen." Learning about death is one of the hardest lessons in contemporary society; however, children can learn and many times the children can teach adults. Any school counselor or other adult working with a bereaved child needs to remember "the two greatest needs of a bereaved child are for affection and a sense of security" (257).

With school counselors, both elementary and secondary, Wolfelt suggests that a death record be kept on each

child/adolescent which can pass from one school to another. As children go through the maturation process, developmental issues can tangle with grief issues. It helps if a school counselor knows the grief history of the child.

In Chapter 12, Corr, Nabe, and Corr (1994), deal with "Adolescents." Adolescence is a hard age to define. Some literature places it from the time a person reaches preteen at age eleven to the early twenties when most young people complete college or enter the working world.

In their discussion of adolescence, the authors use the Fleming and Adolph (1986) breakdown of adolescence into three maturational phases each containing age, developmental task and conflict. The first phase is age 11-14. The task is the emotional separation from parents with the conflict being separation verses reunion (abandonment verses safety). The second phase is age 14-17. The task is the competency/mastery/control with the conflict being independence verses dependence. The third phase is age 17-21. The task is intimacy and commitment with the conflict being closeness verses distance.

During the adolescent years, a person goes through physical, social, and emotional changes. The adolescent is striving for identity and freedom, as he/she tries to develop a stable sense of identity. He/She sees himself/herself as invincible and lives only in the present. It is especially necessary for the adolescent to maintain privacy; a positive body image; an ability

to express individuality, independence and control; and peer interaction. Wolfelt (1996) claims: "With the exception of infancy, no developmental period is so filled with change as adolescence" (p. 271).

Corr, Nabe, and Corr (1994), describe the major causes of death for adolescents are motor vehicle accidents, homicide, and suicide. They go on to relate that these deaths accounted for approximately 77 percent of adolescent deaths (ages 15-24) in 1990. Adolescence is the only time when the top three causes of death are violent, sudden, and "human induced" (p. 273).

The best way to assist young people trying to cope with death is through preparation before the fact, and through support and constructive intervention at the time of and after a death. In many communities, the people do not want death education in the school system as a structured class, but they expect the school system to provide counseling after the fact.

Adolescents coping with bereavement and grief are doing so at a time in life when grief may seem unique, overpowering, and incomprehensible; It is a time when developmental tasks are similar to mourning tasks. By resisting the temptation to solve the adolescent's problems and actively listening, an adult can project confidence in the worth of the adolescent.

Wolfelt (1996) claims: "Teen grief is an area in need of much more research" (p. 270). He contends that the research studies of teen grief have had "inherent" and "methodological" problems. Most studies suffer from one or more of four major

flaws which he declares discredit the results: the biggest flaw is that age-group classifications for adolescence lacks agreement which limits the ability to generalize results. The second flaw is that the majority of research is retrospective, it is an adult looking back at death from a later period in life. This defect results in a variability in the time of reporting responses from when the death took place. Another flaw is the fact that the population lacked randomization, because the captured or clinical samples consisted of adolescents already in treatment for complications of grief. Obviously, this makes for somewhat of a biased sample and affects the ability to generalize results. The last of the four flaws cited is that in some studies, researchers failed to isolate the different types of losses (death, separation, moves, divorce) so the term "loss" became "generic."

School counselors need to make an extra effort with adolescents. Adolescents are neither children nor adults, but a special group of young people who need the opportunity to approach a caring adult. The school counselor should acknowledge every death in a school age child's life. A simple "I'm sorry about _____ 's death. If you want to talk about it, my door is always open." A simple statement allows the student no matter what age to make his/her own decision. The student's agenda, not the adult counselor's agenda is what matters. In all cases, the counselor should be vigilant, and let the student come to him/her. As with the younger students, the counselor should keep a record of the deaths that may affect the student.

Chapter 13 of Death and Dying Life and Living covers the longest part of the lifespan, from approximately the age of 25-65 years of age--"Adults." The developmental tasks in Erikson's (1963) schema encompasses two distinctive eras in the life span for adulthood. Twenty-five to forty-five years old comprises young adulthood where the task is the achievement of intimacy verses the danger of isolation, with the principle theme of productivity and care. By contrast, the major task of middle age (ages 45-65) in Erikson's schema is generativity verses the danger of stagnation, with the principal theme of productivity and care.

"The Elderly" is Chapter 14. The elderly is a growing segment of the population. The distinctive developmental task of older adulthood, striving to achieve ego integrity versus despair, have a direct bearing on how elders relate to death. It is especially important for elders coping with life threatening illness and dying to maintain a sense of self, participate in decisions regarding their lives, be assured that their lives still have value, and receive appropriate and adequate health care services. Suicidal behavior among the elderly appears to arise from the broad psychosocial situation of older adults in American society such as those involving ageism, devaluation, and unresponsiveness to needs. To alter elderly suicidal behavior would require a significant change in social attitudes toward the elderly.

"Part V: Conceptual and Moral Issues" goes into legal issues, euthanasia, suicide and life threatening behavior, and the "meaning and place of death in life." These chapters contain topics which need addressing by every person, but these particular subjects cause the most anxiety. Chapter 15: "Legal Issues" covers important topics, such as, wills, living wills, power of attorney, and other relevant material. It is essential that a person have these legal documents.

When a person reaches the age of eighteen, he/she should have at least a "durable power of attorney for health care." With the advances in medical science, it is valid to have a medical directive stating what extraordinary measures the person may or may not want. Parents of a college age young person may pay for the health insurance for their dependent, but the parents do not have the legal power to make medical decisions if their adult child is mentally or physically unable to make decision as to his/her own care. Likewise, parents should have "living wills" and "wills."

Much of this may sound macabre, but it is better to make sound clear decisions that are well-thought out. Without any directive, a family might have to make difficult decisions under duress causing unnecessary tension and possibly confrontation, or the family may find that doctors or courts are making the decisions.

Chapter 16: "Euthanasia" surveys some of the issue's moral dilemmas. The "right to die" issue is in the forefront of

today's social thinking. People are debating the topic of euthanasia and whether a person has a "right" to terminate his/her life. The primary concern of the discussion in this chapter is to help a person in thinking about the principals and values concerning euthanasia. Most people would hold to the belief that euthanasia is wrong, but what if a person has a terminal illness--and what if that person just happened to be an aging parent--and what if the aging parent is in a great amount of pain? The authors make no effort to advocate a particular view of euthanasia--they present both sides of the issue.

Chapter 17: "Suicide and Life Threatening Behavior" deals with the facts and fables about suicide. The section goes into some reasons why a person commits suicide and problems that arise for the survivors. Since eight of every ten people who kill themselves give definite warnings, people should take every threat or attempt of suicide seriously. The authors give special attention to interventions that individuals and society might initiate to minimize suicidal behavior.

Discussed earlier in Death and Dying Life and Living, when an adolescent dies, usually, it is sudden, and often violent. Automobile accidents are at the top of the list. Researchers claim some of the single vehicular accidents are probably suicide, and at times, the authorities will list a definite suicide as an accident to spare the family undue grief.

Chapter 18: "The Meaning and Place of Death in Life" considers life and death from religious and philosophical

perspectives to students of near-death experiences. "The lesson from all of this is that each person is free to determine for himself or herself the stand that he or she will take in the face of death" (p. 421).

"Part VI: New Challenges and New Opportunities" covers such topics as HIV infections and AIDS, and education. Chapter 19: "HIV Infections and AIDS" looks at the challenges and opportunities associated with infection by the human immunodeficiency virus (HIV), and its end state, Acquired Immunodeficiency Syndrome (AIDS). The HIV/AIDS epidemic reflects many of the patterns that Corr, Nabe, and Corr addresses throughout Death and Dying Life and Living. Chapter 20: "Education About Death, Dying, and Bereavement" reflects on the multiple dimensions, goals, and functions of death education.

Throughout each section of Death and Dying Life and Living, Corr, Nabe, and Corr list other books and materials to assist the reader in locating more materials on specific topics. The book also includes "Appendix A" and "Appendix B" which consist of literature for children from preschool age to literature for high school readers. The completeness of Death and Dying Life and Living makes it a valuable tool for study.

Myths

Another complication that might cause a dilemma when doing grief counseling with a student/client is what Wolfelt (1992 & 1996) calls the "common myths about grief and mourning." Dr. Alan Wolfelt is a prominent authority in the field of grief

counseling. He operates and counsels at his "Center for Loss and Life Transition" in Fort Collins, Colorado. He is a recipient of the Association for Death Education and Counseling's "Death Educator's Award." Wolfelt speaks at workshops and writes about childhood bereavement. Throughout his works, several extremely important themes keep reappearing, and he keeps reiterating these themes over and over. The most important theme is that "grief is a process." A second theme is that "any person old enough to love is old enough to grieve." Another theme is that "every person is an individual" and his/her "journey through the grief process is unique." Finally, a person goes through his/her own "grief journey," and comes to some type of "reconciliation." For a safe journey, it is necessary to dispel the myths.

Many people in society believe one or more of the "myths." It is necessary for a counselor to explore his/her own thoughts concerning these misconceptions and to gain an awareness of how the myths can obstruct the counseling process for a person of any age. In Understanding Grief: Helping Yourself Heal (1992), Dr. Wolfelt explains five myths that can stand in the way of healing in adults, and in Healing the Bereaved Child: Growth Through Grief, and Other Touchstones for Caregivers (1996), he gives ten myths that can harm and block a child's healing process. Although some of the myths for adults and children intertwine, each will be dealt with separately.

General Myths Concerning Grief and Mourning

"Myth #1: Grief and mourning are the same experience." Wolfelt (1992, p. 8) states that although most of the people use grief and mourning synonymously, there is a distinct difference. "Grief is the internal meaning given to the experience of bereavement"; while, mourning is "grief gone public" or when a person takes the "grief on the inside and express it outside."

Adults and children grieve, but society does not encourage them to mourn. Keeping thoughts and feelings bottled up inside can lead to disastrous results. The catalyst for healing is being able to mourn in the presence of "understanding, caring persons who will not judge."

"Myth #2: The experiences of grief and mourning progress in predictable and orderly stages" (1992, p. 9). Elisabeth Kubler-Ross popularized the concept of stages in her landmark book On Death and Dying (1969). Kubler-Ross never meant for people to literally interpret her "stages of dying," but too many people have done just that, and the consequences have often been disastrous.

Wolfelt describes it best:

> The medical model of understanding human behavior actually damages bereaved families because it takes responsibility for healing away from the bereaved person (child, adolescent or adult) and puts it in the hands of the doctor or caregiver who "treats" the "patient." (1996, p. 6).

Wolfelt restates often that every person, whether a child, an adolescent, a young adult, or an older adult, is a unique individual and each person's journey through the grief process is unique. It is necessary to listen to the grieving person for guidance.

"Myth #3: Move away from grief, not towards it." Grief is a unique journey, and everyone moves through it at his/her own pace. Wolfelt states:

> Our society often encourages prematurely moving away from grief instead of toward it. The result is that too many bereaved people either grieve in isolation or attempt to run away from their grief through various means" (1992, p. 11).

When a person ignores or minimizes the grief, he/she creates anxiety, confusion, and depression. He/She begins to fear that his/her thoughts and feelings are abnormal. A person must continually remind himself/herself that leaning toward the pain will facilitate the eventual healing.

"Myth # 4: Following the death of someone loved, the goal should be to 'get over' grief as soon as possible" (p. 12). Wolfelt states:

> In clinical terms, the final dimension of grief is often referred to as resolution, recovery, reestablishment or reorganization. I, however, prefer to use the term **reconciliation** (p. 13).

Reconciliation does not mean "getting over" grief; it means growing through grief.

"Myth # 5: Tears expressing grief are only a sign of weakness" (p. 14). Sometimes people directly or indirectly try to prevent a grieving person from crying out of a desire to protect the mourner or themselves from pain. Crying is nature's way of releasing internal tension and communicating a need for comforting.

Wolfelt states:

> The capacity to express tears appears to allow for genuine healing. In my experience of counseling bereaved people, I have even observed changes in physical expression after crying. Not only do those individuals feel better after crying, they also seem to look better. Tension and agitation seem to flow out of their bodies. The capacity to express tears appears to allow for a genuine healing (p. 15).

Children and the Myths

According to Wolfelt (1996), there are ten myths concerning children and the grief process that need addressing:

1) "Grief and mourning are the same experience" (15). Although children grieve, we as a society do not encourage them to mourn.

2) "Children only grieve for a short time" (p. 63). This is erroneous. Dr. Maxine Harris (1995) wrote an entire book on how adults are encountering grief years after the death of a loved

one because the groups surrounding them did not allow them to mourn when they were children. Wolfelt (1996) states that "grief gets intertwined with the developmental process" (63).

3) "A child's grief proceeds in predictable, orderly stages" (p. 99). Wolfelt restates that "grief is a unique process." Wolfelt describes it best:

> Too often, counselors are taught (and subsequently internalize) the medical model of bereavement care, which suggests that bereaved children are "sick" and need to be "cured." This same mindset implies that the goal in bereavement caregiving is to help the child "resolve" or "recover from" the illness that is "grief" (p. 6)

4) "Infants and toddlers are too young to grieve and mourn." Again, anyone old enough to love is old enough to grieve.

> Unless we support and nurture infants and toddlers when they are confronted with the loss of a primary relationship, they can develop a lack of trust in the world around them. Holding, hugging, and playing with them is the primary ways in which we can attempt to help these young children (P. 119).

5) "Parents do not have to mourn for their children to mourn." Mourning is what Wolfelt calls "grief gone public." Children learn by modeling adult behavior. Parents or other significant adults may mourn privately because they are afraid of upsetting the children. They are not helping their children learn how to mourn, but how to isolate themselves.

> One of the most loving things we can do as bereaved adults is allow ourselves to mourn; the first step in helping bereaved children is to help ourselves. In fact, our ongoing ability to give and receive love depends on our willingness to mourn in healthy ways (p. 145).

6) "Bereaved children grow up to be maladjusted adults." Since the 1930's, historical research has tried to establish relationships between childhood bereavement and adult "mental" illness, such as, depression, psychosis, and sociopathic behavior. Recently the analysis shows "methodological problems" with the studies.

> Bereaved children are not damaged goods . . . if adults create conditions that allow a child to mourn in healthy ways, there is no reason for the self-fulfilling prophesy (p. 197).

7)"Children are better off if they do not attend funerals." The funeral provides a structured environment that encourages both adults and children to comfort each other.

> Children, who after all are mourners too, should have the same opportunity to attend funerals as any other member of the family. They should be encouraged to attend, but never forced (p. 215).

8) "Children who cry too much are being weak and harming themselves in the long run."

> Tears are not a sign of weakness in children or adults. In fact, when bereaved children share tears they are

showing their willingness to do the work of mourning. . . . we can better assist children by crying ourselves when we feel the need to (P. 251)

9) "Children are too young to understand death and religious beliefs about death."

Caring adults need not feel guilty or ashamed if they cannot give specific definitions of God and heaven, or what happens after death. Teaching abstract concepts about death and religion is no easy task, but it's one we must take seriously as we try to help bereaved children (p. 267).

10) "We should help children get over their grief."

Healthy mourning may take a long time--months, years and even lifetimes. In fact, children never overcome grief; they live with it and work to reconcile themselves to it (P. 287).

Grief Counseling

In Understanding Grief: Helping Yourself Heal (1992), from pages 144-150, Wolfelt gives an inventory as to what a grieving person should look for in a counselor to assist him/her. It is necessary to remember that the student/client is the person to make the decision for counseling. His/Her agenda is the one that needs addressing. The attending and communication skills throughout the list are the same as the skills taught to counseling majors at FHSU.

First and foremost, a grief counselor should be emphathetic and understanding. Without empathy, the student/client will feel that the counselor is not listening and hearing, and therefore, lose trust. However, understanding is not the same as total agreement. Sometimes the counselor may understand, but disagree. Even with empathy, disagreement is acceptable.

Second, the grief counselor should give a student/client a clear understanding of how the counseling process can help a person heal. The counselor and counseled need to express their own hopes relating to this experience. They need to create some realistic and mutually agreeable counseling goals.

Third, a grief counselor should be alert, sensitive and caring. The student/client deserves and needs the full attention of his/her counselor. If a counselor is not focused, he/she cannot be effective with the student/client.

Fourth, a grief counselor should not be judgmental. Wolfelt states:

> Sad to say, some people are the victims of misinformed counselors who lack training in bereavement counseling (p. 146).

With the grief process being a unique, individual process, the counselee should do the leading. A judgmental attitude can do a great amount of harm.

Fifth, a grief counselor should encourage the student/client to "teach" him/her. For a counselor to be understanding of a student's/client's unique grief journey, the counselor must be

willing to allow the person become the teacher in this experience.

Sixth, The grief counselor should help the student/client explore areas he/she might want to avoid. Effective counselors use a skill called "supportive confrontation" to help the student/client participate in the hard work of mourning.

Seventh, A counselor should be flexible and open to ideas other than those ideas that reflect only his/her own perspective. Openness to different thoughts and ideas is the mark of a good professional. The "all-knowing expert" who espouses only the "true answers" will do more harm than good.

Eighth, a counselor should be willing to explore other sources of support to assist the student/client. While support groups are not for everyone, some students/clients find them to be a tremendous help. A counselor should know other avenues which a counselee can explore. The counselor should also be aware that he/she might need to bring in other professionals when the student's/client's case requires it.

Ninth, a grief counselor should know the value of a counseling session. A good counselor will bridge from "warm-up time" to more focused ways of helping the student/client work to heal. If the counseling sessions are just pleasant social experiences, the client will not make progress in his/her grief work.

Tenth, a grief counselor should be open and willing to reveal parts of his/her own experience with death that might be

helpful to the student/client. Counselors who are distant, never express emotions, or never talk about their own experiences might be withholding a meaningful interchange. While the main focus should be on the student/client, the counselor should be willing to respond openly with the counselee to any questions he/she has about the counselor's experiences with death.

Eleventh, the grief counselor should be interested in talking to other significant people in the counselee's life. If it is agreeable with the counselor and counselee, family, relatives, and friends can be helpful in the counseling process. If the counselor or counselee totally excludes significant influences, counseling might not be as helpful as it could be.

Twelfth, a grief counselor should practice what he/she advocates. The helpful counselor is one who allows himself/herself to mourn when a death occurs. Practicing good personal "self-care" is essential.

Thirteenth, the grief counselor should be aware that the student/client will be forever changed by the experience of the death of someone loved. The counselor needs to understand that the student/client will not "resolve" or "recover" from grief, but "reconcile" with the grief through "accommodation" or "integration."

Fourteenth, the grief counselor should treat the student/client as an equal and relate with the student/client in a positive way. If a counselor talks down to a student/client,

even a child, the counselor does a great injustice to the student/client.

Fifteenth, the grief counselor should give the student/client a sense of hope for healing; however, both the counselor and the student/client should realize that the death of a close loved person will change the student/client.

Harris (1995) uses the analogy of the loss of someone loved to a tree being struck by lightening and losing a major branch. The part of the tree where the branch existed will heal over, the tree will continue to grow, but the tree will be forever changed. Wolfelt (1996) compares grief counseling to gardening, in fact, he refers to grief counseling as "grief gardening" and he is the "grief gardener." As a seed drops on unfamiliar soil, with watering and nurturing, it grows and blossoms; through understanding and nuturing, a child, adolescent, or adult can reach "reconciliation" with his/her loss.

Death is a mystery, but it is not so mysterious that school counselors should use hushed tones and euphemisms (Nelson, 1977). Many times young people feel that adults do not care, but the real reason is that adults feel uncomfortable talking about death (Elbert, 1982). Society's "protection of children may be a form of avoidance for adults. Society's denial of death is harmful to children (Elder, 1990). Human beings cannot magically make death, loss, and sadness disappear from their lives, but they can study these subjects and share insights with each other as a way of learning to live richer, fuller, and more realistic lives.

The study of death, dying, and bereavement can contribute much to the counseling curriculum (Corr, 1994).

CHAPTER III: APPLICATIONS

After reading and studying Dr. Wolfelt books, Understanding Grief: Helping Yourself Heal (1992) and Healing the Bereaved Child: Grief Gardening, Growth Through Grief and Other Touchstones for Caregivers (1996), the researcher found that it is necessary to be extremely cautious when setting Wolfelt's ideas to any particular "structured" model. Wolfelt is repetitive in stating that every person is "unique," and his/her responses to different grief situations will also be "unique." He stresses that professionals and lay-people have inappropriately used Kubler-Ross' "stages" from On Death and Dying (1969) and they have referred to her "stages of dying" as the "stages of grief." Wolfelt states:

> This type of thinking about dying, grief, and mourning is appealing but inaccurate. Somehow the notion of stages helps people make sense of death, an experience that is usually not orderly or predictable. Attempts have been made to replace fear and lack of understanding with the security that everyone grieves by going through the same stages. If only it were so simple! (1992, p. 9)

Counselors who work with bereaved children, adolescents, and adults think they should always know what to say and do. Wolfelt (1996) claims that many want a "cookbook, prescriptive approach to treating the child. He goes on to say:

> I have found that the need to fill silences and treat bereaved children as patients results from contamination by a medical model of mental health care-giving. This

> model teaches us to study a body of knowledge, assess patients and treat them with hopes of resolving issues and conflicts. In my experience, there is one major problem with this model as it applies to caring for bereaved children--it doesn't work! I have come to realize that the true expert in the counseling relationship is the bereaved child (p. x).

Every person goes through the "grief" process at his/her own pace and in his/her own unique way. The most important thing any person can do for someone who is dying or grieving is to "listen" and facilitate the needs of the person at that particular time.

The school counselor should acknowledge any death that happens in a student's arena. A simple: "I'm sorry to hear about _____'s death. If you want to talk about it, you are welcome to come talk to me." This opening is simple and it lets the child/adolescent know it is acceptable for him/her to approach the counselor about the death. It does not matter whether the death was a person or an animal. Sometimes, the death of a pet is a child's first introduction to death. Pets are not "just a dog" or "just a cat," but it is a very significant loss.

The way a counselor responds to a grieving child can have a profound impact on a child. Wolfelt feels that adults have a unique opportunity to learn from the children. He refers to it as "companioning" bereaved children. He has a handout which he uses that is rather unique in itself. Wolfelt's refers to it as the child's "Grief Rights" (pp. 313-314):

MY GRIEF RIGHTS

A Handout for Bereaved Kids

Someone you love has died. You are probably having many hurtful and scary thoughts and feelings right now. Together those thoughts and feelings are called grief, which is a normal (though really difficult) thing everyone goes through after someone they love has died.

The following ten rights will help you understand your grief and eventually feel better about life again. Use the ideas that make sense to you. Post this list on your refrigerator or on your bedroom door or wall. Re-reading it often will help you stay on track as you move toward healing from your loss. You might also ask the grown-ups in your life to read this list so they will remember to help you in the best way they can.

1. **I have the right to have my own unique feelings about the death.** I may feel mad, sad or lonely. I may feel scared or relieved. I may feel numb or sometimes not anything at all. No one will feel exactly like I do.
2. **I have the right to talk about my grief whenever I feel like talking.** When I need to talk, I will find someone who will listen to me and love me. When I don't want to talk about it, that's OK, too.

3. **I have the right to show my feelings of grief in my own way.** When they are hurting, some kids like to play so they'll feel better for awhile. I can play or laugh, too. I might also get mad and scream. This does not mean I am bad, it just means I have scary feelings that I need help with.
4. **I have the right to need other people to help me with my grief, especially grown-ups who care about me.** Mostly I need them to pay attention to what I am feeling and saying and to love me no matter what.
5. **I have the right to get upset about normal, everyday problems.** I might feel grumpy and have trouble getting along with others sometimes.
6. **I have the right to have "griefbursts."** Griefburts are sudden, unexpected feelings of sadness that just hit me sometimes--even long after the death. These feelings can be very strong and even scary. When this happens, I might feel afraid to be alone.
7. **I have the right to use my beliefs about my god to help me deal with my feelings of grief.** Praying might make me feel better and somehow closer to the person who died.
8. **I have the right to try to figure out why the person I loved died.** But it's OK if I don't find an answer. "Why" questions about life and death are the hardest questions in the world.

9. **I have the right to think and talk about my memories of the person who died.** Sometimes those memories will be happy and sometimes they might be sad. Either way, these memories help me keep alive my love for the person who died.
10. **I have the right to move toward and feel my grief and, over time, to heal.** I'll go on to live a happy life, but the life and death of the person who died will always be a part of me. I'll always miss them.

Reared in today's changing and mobile world, a child might not be in the same educational system from grades K-12. Wolfelt suggests that the school counselor keep a record of "grief encounters" on each student as he/she progresses through a school system. A student who suffered a significant loss as a child can encounter developmental problems as he/she goes through the maturation process--the "loss" could cover any crucial event which might cause a child to grieve. None of these encounters will leave a child/adolescent the same, but each has the potential to help him/her grow as a person. The "grief record" would move with the child much the same way as the school transcript moves from school to school.

Understanding Grief: Helping Yourself Heal (1992) is basically a "self-help" manual. As a person works through the book at his/her own pace, he/she fills in his/her thoughts on each different section. He also gives a nine session support

group plan using the book as a homework book.

Both Healing the Bereaved Child: Grief Gardening, Growth Through Grief and Other Touchstones for Caregivers and Understanding Grief: Helping Yourself Heal books contain a great amount of resource materials that are valuable making them excellent books for a counselor to keep handy. The books contain an abundance of knowledge from how to work with individuals to groups to "Crisis Intervention." Although the books deal with death, it is necessary for a school counselor to remember that some losses in a young person's life can be just as traumatic as death. A long term relationship ending is every bit as painful for an adolescent as death.

The application of the knowledge learned in a course on grief counseling and death education can be beneficial to people working in many arenas: the elementary school counselor; the secondary school counselor; hospice workers; ministers; nurses; geriatric counselors; and many others.

One counselor has used the concepts extensively in working with adolescents and grief; counseling a middle-aged woman who had been her mother's caretaker; counseling a family whose father and husband died unexpectedly; working with young people who are having developmental problems that are grief related; and, the list goes on.

BIBLIOGRAPHY

Adams, D. W. & Deuveau, E. J. (1986). Helping dying adolescents: Needs and responses. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 79-96). New York: Springer.

Attig, T. (1986). Death themes in adolescent music: The classic years. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 32-56). New York: Springer.

Austin, D. A. & Mack, J. E. (1986). The adolescent philosopher in nuclear world. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 57-75). New York: Springer.

Banks, J. A. & Banks, C. A. McGee (Eds). (1993). Multicultural education (2nd edition). Needingham Heights, MA: Allyn & Bacon.

Barnickol, C. A., Fuller, H. & Shinners, B. (1986). Helping bereaved adolescent parents. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 132-150). New York: Springer.

Basque, L. O. & Krieger, B. W. (1974). Death as a counseling concern. Personnel and Guidance Journal, 252, 587-592.

Berman, A. (1986). Helping suicidal adolescents: Needs and Responses. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 151-182). New York: Springer.

Bertoia J. & Allan, J. (1988). School management of the bereaved child. Elementary School Guidance and Counseling, (23), 30-38.

Calvin, S. & Smith, I. (1986). Counseling adolescents in Death-related situations. In C. A. Corr & J. N. McNeil (Eds.), Adolescents and Death (pp. 215-230). New York: Springer.

Corr, C. A. (1984). A model syllabus for children and death courses. Death Education, 8, 11-28.

Corr, C. A., Nabe, C. M., & Corr, D. M. (1994). Death and Dying Life and Living. Pacific Grove, CA: Brooks/Cole Publishing.

Corr, C. A. & McNeil (Eds.) (1986). Adolescence and Death. New York: Springer.

Elbert, A. M. (1982). The forgotten ones: Helping children cope with death. In J. Grimes (Ed.), Psychological Approaches to Problems of Children and Adolescents, (pp. 212-241). Des Moines, IA: Iowa State Department of Public Instruction, Division of Special Education.

Erikson, E. H. (1963). Childhood and Society (2nd ed.). New York: Norton.

Fleming, S. J. & Adolph, R. (1986). Helping bereaved adolescents: Needs and Responses. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 97-118). New York: Springer.

Getson, R. F. & Benshoff, D. L. (1977). Four experiences of death and how to meet them. The School Counselor, (24), 310-314.

Gordon, A. K. (1986). The tattered cloak of immortality. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 16-31). New York: Springer.

Gordon, A. & Klass, D. (1977, May). Goals for death education. The School Counselor, 339-347.

Guy, T. (1993). Exploratory study of elementary-aged children's conceptions of death through the use of story. Death Studies, 17, (pp. 27-54).

Hare J. & Cunningham, B. (1988). Effects of a child bereavement training program for teachers. Death Studies, 12, 345-353.

Hardt, D. V. (1979). Death, the final frontier. Englewood Cliffs, NJ: Prentice-Hall.

Harris, M. (1995). The loss that lasts forever. New York: Penguin.

Hartley, M. P. (1980). Coping with life after death: The counselor's response. Personnel and Guidance Journal, 59, 251-252.

Hodges, M. H. (1988). Adolescent bereavement. Dissertation Abstracts, 50, 3138.

Jones, W. H. (1977). Death-related grief counseling: The school counselor's responsibility. The School Counselor, 24, 315-320.

Kandt, V. E. (1994). Adolescent bereavement: Turning a fragile time into acceptance and peace. The School Counselor, 41, 203-211.

Kastenbaum, R. (1986). Death in the world of adolescence. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and death (pp. 4-15). New York: Springer.

Kubler-Ross, E. (1969). On Death and Dying. New York: Macmillan.

Lamberti, J. W. & Detmer, C. M. (1993). Model of family grief assessment and treatment. Death Studies, 17, 55-67.

Lee, C. C. & Richardson, B. L. (1991). Multicultural issues in counseling: New approaches to diversity. Alexandria, VA: American Association for Counseling and Development.

McBrien, R. J. (1983). Are you thinking of killing yourself?: Confronting students' suicidal thoughts. The School Counselor, 31(1), 75-82.

McNeil, J. N. (1986). Talking about death: Adolescents, parents, and peers. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 185-201). New York: Springer.

Nelson, R. C. (1977). Counselors, teachers, and death education. The School Counselor, 24, 322-329.

Peace, H. G. & Vincent, P. A. (1988). Death anxiety: Does education make a Difference? Death Studies, 12, 337-344.

Peach L. & Reddick, T. L. (1991). Counselors can make a difference in preventing adolescent suicide. The School Counselor, 39, 107-109.

Pine, V. R. (1986). The age of maturity for death education: A socio-historical portrait of the era 1976-1985. Death Studies, 10, 209-231.

Pratt, C. C., Hare, J., & Wright, C. (1987). Death and dying in early education: Are educators prepared? Education, 107(3), 279-286.

Reisler, R. (1977, May). The issue of death education. The School Counselor, 331-337.

Rodman, J. (1997). Crisis Intervention Seminar, Ellsworth High School.

Rosenthal, N. R. (1981). Attitudes toward death education and grief counseling. Counselor Education and Supervision, 20, 203-210.

Rosenthal, N. R. (1986). Death education: Developing a course of study for adolescents. In C. A. Corr & J. N. McNeil (Eds.), Adolescence and Death (pp. 202-214). New York: Springer.

Rosenthal, N. R. & Terkelson, C. (1978). Death education and counseling: A survey. Counselor and Education and Supervision, 18, 109-114.

Schachter, S. (1991). Adolescent experiences with the death of a peer. Omega, 24(1), 1-11.

Schonfeld, D. J. & Kappelman, M. (1992, December). Teaching elementary schoolers about death: The toughest lesson. The Education Digest, 16-20.

Stanford, G. (1977, May). Methods and materials for death education. The School Counselor, 350-360.

Stillion, J. M. (1989). Association for death education and counseling: An organization for our times and for our future. Death Studies, 13, 191-201.

Wass, H., Raup, J., Cerullo, K., Martel, L., Mingione, L., & Sperring, A. (1988). Adolescents' interest in and views of destructive themes in rock music. Omega, 19(3), 177-186.

Weeks, D. (1989). Death education for aspiring physicians, teachers, and funeral directors. Death Studies, 13, 17-24.

Weeks, D. & Johnson, C. (1992). A second decade of high school death education. Death Studies, 16, 269-279.

Weisman, A. D. (1991-92). Commentary on Corr's "a task-based approach to coping with dying." Omega 24(2), 91-92.

Wolfelt, A. D. (1996). Healing the bereaved child: Grief gardening, growth through grief, and Other Touchstones for Caregivers. Fort Collins, CO: Companion Press.

Wolfelt, A. D. (1992). Understanding grief: Helping yourself heal. Bristol, PA: Accelerated Development.